



IDAHO DEPARTMENT OF
HEALTH & WELFARE

COPY

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3232 Elder Street
P.O. Box 83720
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PHONE 208-334-6626
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September 23, 2009

Rene Stephens
Hillcrest Home
1411 Falls Avenue East, Suite 703
Twin Falls, ID 83301

Provider #13G048

Dear Ms. Stephens:

On September 18, 2009, a follow-up visit of your facility was conducted to verify corrections of deficiencies noted during the survey of May 14, 2009.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. It is important that your Plan of Correction address each deficiency in the following manner:

1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;
2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;
4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,

Rene Stephens
September 23, 2009
Page 2 of 2

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **October 6, 2009**, and keep a copy for your records.

Your copy of a Post-Certification Revisit Report, Form CMS-2567B, listing deficiencies that have been corrected is enclosed.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2007-02. Informational Letter #2007-02 can also be found on the Internet at:

<http://www.healthandwelfare.idaho.gov/site/3633/default.aspx>

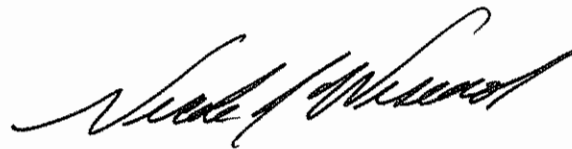
This request must be received by October 6, 2009. If a request for informal dispute resolution is received after October 6, 2009, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If we can be of any help to you, please feel free to call us at 334-6626.

Sincerely,



MATT HAUSER
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MH/mlw

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/22/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 09/18/2009
NAME OF PROVIDER OR SUPPLIER HILLCREST HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2115 HILLCREST DRIVE TWIN FALLS, ID 83301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{W 000}	INITIAL COMMENTS The following deficiency was cited during the follow-up survey. The surveyors conducting the survey were: Matt Hauser, QMRP, Team Leader Monica Williams, QMRP Common abbreviations used in this report are: IPP - Individual Program Plan NOS - Not Otherwise Specified QMRP - Qualified Mental Retardation Professional	{W 000}			
{W 227}	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure the IPP included objectives to meet the needs for 2 of 3 individuals (Individuals #1 and #2) whose IPPs were reviewed. This resulted in a lack of program plans designed to address the needs of individuals in areas most likely to impact their lives. The findings include: 1. Individual #1's IPP, dated 6/5/09, documented a 36 year old male diagnosed with moderate mental retardation, psychosis NOS, attention deficit disorder, and eating disorder. a. Individual #1's Physician Orders, dated 4/20/09, showed he received Prozac (an	{W 227}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Rene Stephens

Administrator

10/7/09

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{W 227}	<p>Continued From page 1</p> <p>antidepressant drug) 30 mg a day for compulsive eating.</p> <p>His Medication Reduction Plan, dated 6/09, included an objective related to his bingeing and purging behavior. However, the objective in the Medication Reduction Plan was not incorporated into Individual #1's IPP.</p> <p>When asked, the QMRP stated during an interview on 9/18/09 from 8:30 - 9:30 a.m., the objective in Individual #1's Medication Reduction Plan was not incorporated into his IPP.</p> <p>b. Individual #1's Physician Orders, dated 4/20/09, showed he received Seroquel (an antidepressant drug), Depakote (an anticonvulsant drug), Lithium (a central nervous system drug), and Risperdal (an antipsychotic drug) for psychosis.</p> <p>His Medication Reduction Plan, dated 6/09, contained objectives related to agitation, pacing and pressured speech, internal stimuli, and hitting others and property destruction. However, the objectives in the Medication Reduction Plan were not incorporated into Individual #1's IPP.</p> <p>When asked, the QMRP stated during an interview on 9/18/09 from 8:30 - 9:30 a.m., the objectives in Individual #1's Medication Reduction Plan were not incorporated into his IPP.</p> <p>The facility failed to ensure objectives and plans were developed for Individual #1.</p> <p>2. Individual #2's IPP, dated 9/22/08, documented a 58 year old male diagnosed with severe mental retardation, severe Parkinson's disease, and</p>	{W 227}			

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{W 227}	<p>Continued From page 2</p> <p>cerebral palsy.</p> <p>a. Individual #2's Physician's Orders, dated 6/3/09, documented he received Atarax (an anti-anxiolytic drug) 25 mg twice daily. His Medication Reduction Plan, dated 9/22/08, documented he received the drug for "itchy legs." However, Individual #2's IPP did not contain an objective to address his leg scratching.</p> <p>When asked during an interview on 9/18/09 from 8:30 - 9:30 a.m., the QMRP stated there was no objective to address Individual #2 scratching his legs.</p> <p>b. Individual #2's Physician's Orders, dated 6/3/09, documented he received Sinequan (an anti-depressant drug) 50 mg at bedtime. His Medication Reduction Plan, dated 9/22/08, documented he received the drug for sleep. However, Individual #2's IPP did not contain an objective to address his sleep hygiene needs.</p> <p>When asked during an interview on 9/18/09 from 8:30 - 9:30 a.m., the QMRP stated there was no objective to address Individual #2's sleep needs.</p> <p>The facility failed to ensure specific objectives and formal plans had been developed to address identified needs for Individual #2.</p> <p>Repeat Deficiency</p>	{W 227}			

PRINTED: 09/22/2009
FORM APPROVED

Bureau of Facility Standards

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{MM729}	16.03.11.270.01(d) Treatment Plan Objectives The individual treatment plan must state specific objectives to reach identified goals. The objectives must be: This Rule is not met as evidenced by: Refer to W227.	{MM729}			

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

TITLE

(X6) DATE

IMY412

If continuation sheet 1 of 1